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## AFRICAN HEALTH SYSTEMS – OUR FRONTLINE IN THE COVID-19 PANDEMIC BATTLE?

Health workers in low income countries (LICs) find it difficult and often financially unrewarding, and are often taken for granted, when the national cake is being shared. The same may be said for teachers and other critical social sector workers who help to determine the foundations of social development and long term economic well-being.

Our economics, however, seems to focus on wealth creation for a few with mostly accumulation by individuals without adequate attention to investments in broader equity and well-being. After all, the economic indicators will still show good GDP “growth”.

But when a pandemic strikes, as we are witnessing now, the years of political lip service and the absence of serious investment in building functional health systems become painfully obvious. For example, the National Health Insurance Schemes being initiated in some countries do not set aside a proportion of their funds for epidemics (and in one country I know, actually was used to fund scholarships for politicians to attend non-health related courses in the United States).

I once spent time visiting a patient in an intensive care unit (ICU) somewhere in Africa, and being there almost daily for about a month, I was shocked that all visitors had to use and recycle between them the same set of torn, disposable protective gowns and boots day after day with no evidence of any disinfection taking place between use, let alone being replaced with new gowns. My patient did pass away from a hospital-acquired infection that was resistant to multiple antibiotics. It made me also worried about what this meant in terms of illness rates among the nurses and other workers in such situations.

How much would it cost to invest in local or regional production of, say, disposable gowns for health-care

and food-industry workers, and protection for sanitation workers, for example? Against building a shiny new parliamentary debating (hot air) chamber or a new presidential palace; or acquiring large numbers of expensive 4-wheel drive vehicles for the political class? We do now have a situation arising from the pandemic, with closed airports and banned travel, where nobody can easily leave and get their treatment abroad, as was quite common. We all have to use the limited number facilities with the few ventilators and critical care staff available to us here in Africa.

We had the very serious Ebola scare in West Africa (and recently in DRC) that received a lot of international attention but it appears once that was over, and despite several assessments to look at the compliance with international health regulations through joint external evaluations (JEEs), things seemed to have returned to “normal” with a few changes here and there but a lack of purposeful transformation of health services and systems. Even the handwashing and sanitizing that was so effective against Ebola as well as cholera, the common cold, etc, which could have helped with COVID-19, seemed to have been abandoned.

Of course in the absence of these simple investments and appropriate preparatory and response training, in a major hospital in Ghana, health workers apparently left their stations when rumours circulated of a suspected COVID-19 case. Now the COVID-19 tragedy is equally affecting rich countries and it is difficult to expect the same level of support as was received during Ebola.

We need a fundamental change in holding African leaders and managers more accountable and responsible to their populations. We must establish independent mechanisms to monitor the anticipation of the health challenges and disasters that are becoming more and more common and ensure that Africa has a ‘peacetime readiness’ capacity to respond quickly when the inevitable occurs. Our low and middle-income countries, facilitated by the regional economic communities, need to invest in and monitor sharpened and responsible common-sense stewardship that insulates our national and continental health systems from toxic politics and corruption.

What can we do? I recall once making a presentation to a visiting Minister of Health during my time in the WHO Africa Regional Office and showing data indicating their country’s huge (60+%) ‘out-of-pocket’ expenditure on health and how it undermined their universal health coverage (UHC) “commitments”. I got a loud sounding off on how much ad-hoc money “his excellency” the President had been allocating to health needs! However, this lecture gradually turned into a “plea” to be more diplomatic in conveying “bad news”.

To get the results Africans need, we must invest, as urgent priorities, in the following, even as we battle this pandemic:

1. Efficient health information, communication and alert systems that are needed to know what goes on in our health systems. (For example, few WHO African countries have competent civil registration and vital statistics (CRVS) systems covering more than 50% of their populations, so our denominators are estimates).
2. Regular continuing professional development, capacity building and supervision of the workforce and to build morale and also provide sensible infrastructure, equipment, and protective apparel and logistics. (In many countries health workers are not covered by health insurance and are rarely fully protected against catastrophic health expenditure. How can they risk their lives in a pandemic like the COVID19 one?)
3. We must build a health security workforce outside of the regular workforce. For example, having competent contact tracers during a major outbreak distributed across the country and mobilized when needed.
4. We must make sensible investments in equitable infrastructure and services so that political leaders as well as ordinary citizens can confidently expect and receive quality services as opposed to

seeking treatment abroad.

5. We must design national and continental frameworks to peer review and assess health leadership actions and results and their impact on people lives.

African countries must by now recognize that when that dire emergency happens, your life will be best saved by local health facilities and not a long flight abroad. We have to enhance our emergency health services capacity and the preparedness and preventive plans and investments as part of how we assess UHC. Each country should plan for and be able to rapidly expand emergency facilities using designated schools, hotels, etc to protect the population when disaster strikes.

Pathogenic microbials will not always oblige us by coming from outside the country and through airports. Health security should be a very visible part of every national security system and should keep track of all unusual morbidity and deaths across a country and its communities.

We must educate on and enforce our Public Health laws and train special sections of the police, army and immigration/customs, etc on how to safely ensure a population compliance with public health actions when our security faces a disaster.

We have well-trained health professionals who know what to do, but “capacity” is three dimensional i.e., knowledge, competence and their utilization is only effective if the numbers of qualified professionals are adequate and are well distributed across the country and empowered to take decisions and utilize resources without undue non-technical or political interference.

In one country that I'm familiar with, I was stunned when local health field managers complained about new staff postings being mostly of a “protocol” nature (these staff are posted at the behest of an influential person or politician to a specific duty station – usually an already fully filled urban or otherwise desirable location). Important deprived locations are left empty, undermining staff morale and discipline there, and discouraging staff from serving in disadvantaged areas.

This COVID-19 pandemic provides an opportunity for reflection and a return to professionalism with investments in public health and in providing dignified services for even our poorest citizens. Let's create workplaces that foster high morale and help to protect staff.

Africans deserve better health systems – or else better leaders.

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